

Department of Mental Health
VSH Futures Project
Corrections Inpatient Workgroup Report
March, 2008

Table of Contents

Corrections Inpatient Work Group Report	2
Background	2
Corrections Component of Futures Plan.....	3
Formation of Work Group	3
The Work Group's Charge.....	4
Planning for Corrections Beds	4
Analysis of Inpatient Capacity Needs for Corrections	4
Assessment of Broader Mental Health Needs in Corrections	5
Inpatient Forensic Admissions and Commitments.....	6
Discussion on Range of Issues	6
Summary Recommendations	7
LIST OF ATTACHMENTS	8

VSH Futures Project Corrections Inpatient Work Group Report

Background

The Department of Corrections (DOC) primary mission is to provide public safety via supervision and secure containment of nearly 1,700 inmates daily. In addition, DOC is responsible for providing health and mental health care to inmates, but is not responsible for providing these services for individuals on probation and parole. Many incarcerated individuals have health and mental health conditions that may require treatment during the course of their sentence. Much of this care is consistent with out-patient care provided in medical and mental health settings in the community. A subset of incarcerated individuals will be ill enough to require hospital-level care for treatment of medical or mental health conditions.

In the past decade the DOC has contracted with an independent mental health provider to meet the day-to-day mental health needs of the incarcerated population. The DOC also has developed new, more intensive mental health programming at the Dale and Southern State Correctional Facilities. When an inmate develops symptoms of mental illness that are too acute to be addressed within the DOC facilities, the most common referral for psychiatric hospitalization is to Vermont State Hospital. Upon stabilization, inmates are returned to a DOC facility and to the custody of the Commissioner of Corrections.

There have been a number of concerns consistently expressed by consumer advocates, family members, DOC staff, and others that the plan to address the needs of the acutely mentally ill inmate be adequate to meet the needs of this population. The Futures effort was inclusive of consultation and planning with DOC and there was an independent actuarial study of the DOC capacity needs for the VSH successor programs. In addition, the Department of Mental Health (DMH) engaged in a review of this need with community partners, advocates, and DOC leadership to assure that there is a clear understanding of what the needed capacity for acute psychiatric inpatient care is for the DOC incarcerated population.

To perform the review with partners and advocates, the Futures project formed a work group comprised of DOC and DMH administrators, clinical leaders, mental health providers, and advocates to develop a methodology to estimate the psychiatric inpatient capacity needed for Corrections. The group has met monthly since March 2007 and submits this report of its findings.

Corrections Component of Futures Plan

An essential element of the Futures Plan is how to provide for the inpatient psychiatric needs of individuals who are incarcerated in Vermont's correctional system. To the extent that prison inmates have mental health disorders requiring hospital-level care, Vermont State Hospital is responsible for providing treatment. Accordingly, successor inpatient facilities to VSH must have sufficient capacity to accommodate individuals who are committed to the care and custody of the Commissioner of Corrections.

To address this issue, the Futures planning process estimated Corrections capacity needs in several ways. The first comprehensive report on the Futures Plan issued in 2005¹ spoke to the psychiatric inpatient program needs of incarcerated people with an acute mental illness. Based on historical data, the Department of Corrections estimated that up to eight individuals require such services at any given point in time. An actuarial study commissioned by the Futures project in 2006² identified the Corrections population as an important subset of the users of adult inpatient mental health services. The study confirmed that the Corrections population was accounted for in their data analysis of the Vermont State Hospital admissions on which psychiatric inpatient capacity projections are based. Given that planning parameters for the Corrections population up to this point were based primarily on past utilization, a more sufficient and reliable working estimate would have to be developed. This was the core task of the Corrections Inpatient Work Group and its clinical subcommittee.

Formation of Work Group

A major area of study for the Department of Mental Health and the Futures Advisory Committee was how to meet the psychiatric inpatient needs of people committed to the care and custody of the Commissioner of Corrections. A work group to address these issues was formed in March 2007. The departments of Mental Health and Corrections shared responsibility for guiding the work group through its deliberations and focusing on the core task of estimating Corrections' psychiatric inpatient capacity needs for successor programs to Vermont State Hospital. A clinical subcommittee examined the criteria for psychiatric hospitalization used by community mental health, determined how the criteria could be applied to a Corrections environment, and established a basis for estimating the psychiatric inpatient bed capacity needs for Corrections.

The work group met eight times, March through November 2007. The subcommittee held one meeting, completed its analysis, and reported its conclusions to the work group. Serving on the work group were the medical directors of Mental Health and Corrections, a community mental health emergency services director, Corrections mental health unit supervisor, Mental Health acute care program administrator, family, consumer, and legal rights advocates. Corrections chief of mental health services and Mental Health deputy

¹ Vermont State Hospital Futures Plan – Report to Charles Smith, Secretary, Agency of Human Services (Department of Health, Division of Mental Health, February 4, 2005, Page 75)

² Actuarial Study of the Needed Bed Capacity for Adult Mental Health Inpatient Services (Milliman, Inc., June 2, 2006, Pages 16-21)

commissioner served as co-chairs. Work group meetings, minutes, and documents were all open to the public. Work group and subcommittee membership lists are attached.

The Work Group's Charge

The principal focus of the work group was to review the current criteria for admission to psychiatric inpatient care and consider how these criteria may need to be adapted to apply to an incarcerative (rather than community) environment. Based on the hospital admission criteria, the group developed a methodology to estimate the psychiatric inpatient capacity needed by the Department of Corrections.

Planning for Corrections Beds

The *ad hoc* subcommittee of mental health clinicians and psychiatrists from the community, Vermont State Hospital, and the Corrections system fulfilled these tasks:

1. Review current mental health admission standards to a psychiatric hospital unit.
2. Evaluate these procedures in relation to the needs of inmates.
3. Review the experience of Corrections in seeking emergency examinations (involuntary acute admission for psychiatric care).
4. Identify the elements of the current emergency examination standards that are appropriate for a corrections environment and those that require modification.
5. Recommend clear guidelines on how to apply the emergency examination process within a correctional facility.

The subcommittee sought to afford inmates of the Department of Corrections with equivalent access to acute psychiatric inpatient care as for the general population in Vermont. The Psychiatric Hospitalization Criteria proposed by the subcommittee and endorsed by the work group utilize current hospital admission criteria for all citizens of Vermont. These criteria have a long history, have clinical validity, and are generally accepted by most clinicians in the field. Some clarifications were needed, however, for their application to people in residence at a correctional facility. (See attachment.)

Analysis of Inpatient Capacity Needs for Corrections

The methodology to estimate the psychiatric inpatient capacity needed for Corrections consisted of a case-by-case review of all admissions to the male and female specialty mental health units from September 1, 2006 through August 31, 2007. In performing this review, MHM Services with whom the Department of Corrections contracts for delivery of mental health services to incarcerated individuals, applied the criteria for psychiatric hospital admissions that was developed by the work group's *ad hoc* subcommittee.³

The number of referrals to Vermont State Hospital that would have occurred, had the updated criteria been in place, was determined using this methodology. To further

³ Dr. Harlow Ballard, Medical Director of MHM Services in Vermont, conducted the review. Dr. Ballard has long-term experience with inpatient psychiatric care and community mental health from his work as a staff psychiatrist at Central Vermont Medical Center and at Washington County Mental Health Services.

validate the results, MHM Services consulted all other DOC facilities to make sure that there were no other inmates in the system (outside of the mental health units) who might

have met criteria for inclusion in the data analysis. Finally, an estimate of hospitalization duration, i.e., bed days, was made for each of these referrals. MHM Services was then able to estimate the total number of inmate bed days for the year in question.

The result of this analysis indicates the following:

- A total of 24 people incarcerated in DOC facilities would have been referred to Vermont State Hospital using the inpatient admission criteria developed by the *ad hoc* subcommittee and recommended by the full work group.
- Six of these individuals were served at VSH for total use of less than one bed per year (.7).
- Assuming the 18 additional referrals (over the previous calculation) have a similar length of stay at VSH, the inpatient treatment need for Corrections is 2-4 beds.
- Each bed would be used for 43 days, which is a longer length of stay than the general population using community admission criteria. (The average length of stay for people admitted to VSH from the community is 35 days.)

As this level of capacity was derived from the sound methodology and detailed analysis of the subcommittee, it provides the Futures planning process with the most reliable working estimate to use in Futures planning.

While beyond the scope of the work group's charge, the hospital admission criteria so developed is now available to the clinical leadership of VSH and Corrections, providing both systems with a consistent framework for referrals.

Assessment of Broader Mental Health Needs in Corrections

The work group did not limit its discussion to the subset of inmates whose mental health treatment needs require hospitalization. The MHM Services contract shed light on the specific mental health services available to inmates. The Comprehensive Mental Health Services Plan⁴ developed two years ago with the input of multiple stakeholders provided context of the Department of Corrections' statutory requirements, mission, and principles for serving the clinical mental health needs of inmates in a comprehensive and integrated fashion. What became clear to members of the work group was the necessity of speaking not only to the replacement of inpatient capacity but also to the broader range of inmates' mental health needs across the system.

The analysis of inpatient capacity needs for Corrections forecasts how many psychiatric inpatient beds will be needed for the most acutely ill inmates in the successor programs to Vermont State Hospital. Along with this forecast, the work group points out the need to address the more basic levels of need for mental health services as well as the long-term needs of people who have been incarcerated in the Correctional system. The number of acute-care psychiatric beds to plan for, between 2 and 4, does not reflect the full scope of

⁴ Report by the Commissioner of Corrections to the Joint Legislative Corrections Oversight and Mental Health Oversight Committees (January 15, 2005)

mental health needs of inmates. System capacity planning for Corrections should address the broader concerns of all inmates.

Inpatient Forensic Admissions and Commitments

An understanding of the legal framework under which a district court may send a criminal defendant to VSH or another designated hospital for either a forensic evaluation or for involuntary treatment was an essential component of the work group's study. The Department of Mental Health's Legal Division provided explanation of these processes and a summary of pertinent state statutes.

Discussion on Range of Issues

While maintaining focus on its core task---to develop a methodology to estimate the psychiatric inpatient capacity needed by the Department of Corrections---the work group covered a wide range of issues related to corrections and mental health. The discussions served to inform work group members and the broader policy development process in DOC and in the Legislature. The work group's concerns and suggested approaches are:

- The mental health treatment program for which DOC contracts with MHM Services, Inc. has about 13 FTE social workers and 3.5 FTE physicians / psychiatric nurse practitioners providing screening to all prisoners, crisis intervention as needed, and medication management. The intent of this treatment is to stabilize the inmate sufficiently so that he or she can be safely managed in the general population of Corrections.
- The specialty mental health units at the Southern State Correctional Facility in Springfield, Vermont are evolving. The Alpha unit, a 10-bed stabilization unit for individuals having a psychiatric crisis, provides acute, short-term (3-5 days) stabilization services for inmates. The Bravo unit is 24 beds and offers some additional supports beyond the general corrections environment. Improved programming in the Alpha unit, i.e., a more robust menu of services, would enhance that facility's current treatment capability beyond crisis intervention and stabilization.
- The prison environment is essentially un-therapeutic and therefore may exacerbate underlying conditions such as mental illness. Some work group members questioned whether long-term incarceration is even appropriate for offenders with mental illness who have committed non-violent, victimless crimes, and support diversion programs as an alternative to just locking people up, when their primary need is to access community-based treatment.
- The SMI ("Serious Mental Illness") list, used to accord inmates accommodations and protections when Corrections is applying directives such as segregation, is too narrowly drawn to afford inmates with other cognitive deficits the protections envisioned consistent with the spirit of the statute.

- The Department of Corrections mental health services provider, MHM Services, advises that 37 percent⁵ of the incarcerated population in Vermont is receiving some type of psychotropic medication, including “minor” / over-the-counter medications for sleep such as Benadryl and melatonin. While this represents a reduction in the widespread use of psychotropic medications among incarcerated individuals, the issue remains a concern.
- To address concerns about the adequacy of mental health treatment services for inmates in general, expand mental health and substance abuse treatment options at Vermont’s correctional facilities. Develop services for a broader range of people than the much more limited subset of incarcerated people who require acute care.
- The mental health services that DOC contracts to provide incarcerated individuals fall short of needs. The limitation of treatment options and the incarcerative environment are a combination that can result in allowing people to essentially fall off a cliff---to reach a point at which they meet hospital admission criteria---rather than to receive appropriate mental health services geared toward recovery.
- Designated community hospitals, which operate psychiatric units under contract with the Department of Mental Health, are an essential component of Vermont’s public system of mental health care. These hospitals could be positioned to provide care for psychiatric patients with a high level of acuity, including those individuals who come from an incarcerated environment. The hospitals’ staffing, infrastructure, and programming needs must be identified and addressed to enable them to serve incarcerated individuals for whom inpatient psychiatric treatment is clinically appropriate.

Summary Recommendations

1. Finalize the Psychiatric Hospitalization Criteria with the clinical leadership of the Departments of Mental Health and Corrections, and move the guidelines forward to accomplish statewide application.
2. Incorporate a total of 2 – 4 beds in the Futures Plan to meet the inpatient treatment need for Corrections. This number of beds reflects acute-care needs only, not the full spectrum of mental health needs for incarcerated individuals in Corrections.
3. Expand mental health and co-occurring treatment programming for incarcerated individuals that more closely match outpatient and Community Rehabilitation and Treatment (CRT) services. This offers significant potential payback in terms of improved public safety, reduced recidivism, and costs to society in addition to supporting offenders’ interest in rehabilitation and recovery.

⁵ This number is based on data from October 2007.

LIST OF ATTACHMENTS

Attachment 1	Psychiatric Hospitalization Criteria: Futures Bed Planning for Department of Corrections
Attachment 2	Inpatient Forensic Admissions and Commitments (DMH Legal Division, 9/25/07)
Attachment 3	Corrections Inpatient Work Group Charge <i>Ad Hoc</i> Subcommittee on Emergency Exam Standards Charge
Attachment 4	Corrections Inpatient Work Group Member List <i>Ad Hoc</i> Subcommittee members (listed with Attachment 1)

VSH Futures Project Psychiatric Hospitalization Criteria Bed Planning For DOC

In order to plan the number of beds needed by the Department of Corrections for residents who have mental health needs rising to the level of hospitalization, the *Ad Hoc* Subcommittee of the Corrections Inpatient Work Group recommends that we utilize current hospital admission criteria for all other citizens of Vermont. These criteria have a long history, have clinical validity and are generally accepted by most clinicians in the field. There are some points of clarification needed when applied to people in residence at a corrections facility.

There are two general categories for hospitalization in practice currently in Vermont: voluntary and involuntary.

Hospital Admission Criteria

- Must have a diagnosis or suspected mental illness **and**
- A danger to self or others **or**
- Unable to care for self with potential for imminent serious harm to self **or**
- Unable to care for others in his/her care which would be dangerous to other **or**
- In need of twenty-four hour medical supervision for the treatment of a mental health disorder with complicating physical health factors **or**
- In need of rapid evaluation due to complex diagnostic factors in which there is significant risk of deterioration **or**
- Unable to be managed at a lower level of care sufficient to prevent serious deterioration **or**
- Appropriate for a lower level of care but no less intensive alternative is available that would prevent serious deterioration
- All of the above would need to exceed the DOC ability to provide the necessary treatments within the correctional facility

Involuntary criteria are based in statute and case law. There are three basic components, mental illness, dangerousness and a less restrictive setting will not suffice. In addition to hospitalization criteria being met all three involuntary criteria must also be met for an individual to be eligible for involuntary emergency examination.

Mental Illness (See statute for legal definition for emergency examination.)

- All Axis I and Borderline Personality Disorder in Axis II of the DSM system fit this criteria.

- Anti-social personality disorders typically is by itself insufficient to be eligible.
- Mental retardation is ineligible if it is the primary reason for considering hospitalization.
- Usually most forms of organic brain syndrome, such as the dementias or traumatic brain syndrome are not hospitalized on psychiatric units.

Dangerousness (See statute for legal definition of emergency examination.)

- Generally the same standard as used in the community setting is applicable.
- Self-injurious behaviors meet criteria for short stays in order to stabilize, but not for prolonged, vacillating risk of self-harm. In general, individuals who are at continuing risk of self-harm fair worse in a hospital setting than in a lower level of care with appropriate treatments.
- Dangerousness is considered to still be an issue when it is necessary to keep a mentally ill person isolated from the general milieu most of the time to provide protection from self or others.
- Deteriorating physical health when mental illness is a significant contributor is eligible when further delay in accessing care would cause irreparable harm.

Least Restrictive Environment

- Implicit in this criterion is the concept that the environment is the least restrictive place where the mental health treatments can be provided and the dangerousness managed. The person should be in the setting which can provide the treatment to return the person to baseline functioning.

Ad Hoc Subcommittee

of Corrections Inpatient Work Group

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MEMORANDUM

To: Corrections Inpatient Work Group

Fr: DMH Legal Division

Date: September 25, 2007

Re: Inpatient Forensic Admissions and Commitments

This memorandum describes the processes under which a district court may send a criminal defendant to VSH or another designated hospital for either a forensic evaluation or for involuntary treatment. The forensic evaluation process provides for a short hospitalization for the express limited purpose of having a criminal defendant evaluated by a forensic psychiatrist. The second type of hospitalization, involuntary treatment, allows the district court to commit an incompetent and/or insane defendant to the care and custody of the commissioner for a 90-day order of hospitalization. The forensic evaluations involve roughly 100 inpatient admissions (vast majority at VSH) per year, around one-half of those evaluations result in the defendant being adjudicated as incompetent and/or insane. A smaller group of those insane or incompetent defendants are then committed to VSH for treatment. The separate procedures for forensic evaluation and involuntary hospitalization are described in more detail below. A flow-chart detailing the actual numbers of inpatient evaluations for fiscal year 2007 is attached.

Forensic Evaluations – 13 V.S.A. § 4814-4817

A district court may order DMH to evaluate a criminal defendant to determine if the defendant is mentally **competent to stand trial**⁶ and/or was **insane at the time of the offense**.⁷ DMH contracts with four forensic psychiatrists who submit written evaluations to the court. The statute requires that evaluations be completed in the least restrictive setting necessary to complete the examination. Evaluations can be completed on an outpatient basis, in a correctional facility, or on an inpatient basis at VSH or other designated hospital. *The courts order roughly 100 inpatient evaluations per year.*

⁶ A defendant is competent if they have the ability to rationally consult with a lawyer, and have the rational and factual understanding of the criminal proceeding.

⁷ A defendant is insane if at the time of the offense if as a result of mental disease or defect, they lacked the capacity to either appreciate the criminality of their conduct or conform their conduct to the requirements of the law.

Before the court orders the evaluation, the defendant is supposed to be screened by a mental health professional from the local community mental health center. These qualified mental health professionals or “QMHP”s are designated by the commissioner to perform this and other pre-admission screenings. The screener makes a recommendation to the court on where the competency/sanity evaluation should take place. The recommendation is based in part on whether the defendant meets **civil commitment criteria**⁸ and needs an inpatient level of care. The courts follow the screeners’ recommendations in most, but not all cases.

The court’s order authorizes an involuntary hospitalization for up to 30 days. The contracts with the forensic psychiatrists require that the evaluations be completed within seven days. If the psychiatrist reports that the defendant is competent and sane DMH may ask the court to have the defendant returned to court within 48 hours so that they can be discharged from the hospital. The court will hold a **competency hearing** either before or after the defendant is discharged from the hospital. If the court determines that the defendant is incompetent to stand trial or the psychiatrist reports that the defendant was insane the court may order that the defendant remain in the hospital pending a **commitment hearing**

Forensic Commitments for Treatment – 18 V.S.A. § 4820-4822

An individual may be committed to the care and custody of the commissioner for a 90-day order of hospitalization through a **criminal case in a district court** or a **civil commitment case in family court**. Generally, a criminal defendant is only committed to VSH for treatment if they have been determined to be incompetent and/or insane. The court holds a hearing specifically to determine if the defendant is a “**person in need of treatment**” in that they pose a danger to themselves or others as a result of a mental illness.

After a defendant is committed to the hospital for treatment, it is usually up to the treatment providers to decide when the individual will be transitioned to the community. However, in some cases where the offense involved a threat of injury or actual injury, the court may order that a discharge hearing be held before the individual can be discharged from custody. This discharge hearing requirement leaves the court with absolute control over the individual’s transition to the community and in some cases substantially prolongs the period of hospitalization beyond what is clinically indicated and explains why some patients remain at VSH for decades.

⁸ The statutory definition of a “person in need of treatment” that poses a danger to themselves or others are a result of mental illness is codified at 18 V.S.A. § 7101(17).

VSH Futures Project Corrections Inpatient Work Group

Work Group Charge

The charge of the Futures Corrections Inpatient Work Group is to develop a methodology to estimate the psychiatric inpatient capacity needed by the Department of Corrections.

The methodology will:

- 1) enable Corrections to estimate the number of individuals who are incarcerated or detained who need inpatient psychiatric treatment at any given time; and
- 2) enable the Futures Project to plan for an appropriate psychiatric inpatient capacity to meet this need.

To carry out this charge the work group will undertake the following tasks.

- Clarify what is meant by “forensic” and develop common definitions.
- Review the current criteria for admission to involuntary psychiatric inpatient care and consider how this may need to be adapted to apply to an incarcerative (rather than community) environment.
- Formulate an approach, based on these admission criteria, to estimating the need for psychiatric inpatient care among the incarcerated and detained population in Corrections.

The Department of Corrections and the Division of Mental Health will co-chair the work group. The work group will report its findings and recommendations to the Futures Advisory Committee and to the Secretary of Human Services.

The work group shall do its work in a manner similar to other work groups of the Futures project, providing public notice and minutes of meetings as well as seeking and considering input from stakeholders in the mental health and corrections communities.

March 19, 2007

**VSH Futures Project
Corrections Inpatient Work Group
Ad Hoc Subcommittee on Emergency Exam Standards**

Ad Hoc Subcommittee Charge

An *ad hoc* subcommittee is formed to advise the Corrections Inpatient Work Group on how to implement current emergency exam (EE) standards in a Corrections environment.

The subcommittee will undertake the following tasks:

- review current mental health screening standards for admission to the Vermont State Hospital;
- evaluate these procedures in relation to the needs of inmates;
- review the experience of Corrections in seeking emergency exams for inmates;
- identify elements of the current emergency exam standards that are appropriate for a Corrections environment and those that require modification; and
- recommend clear guidelines on how to apply the emergency exam process within a correctional facility.

The work product of the subcommittee will be used in developing an estimate of needed inpatient psychiatric bed capacity for individuals who are incarcerated or detained by the Department of Corrections at any given time.

May 9, 2007

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